BONELA

The Botswana Network on Ethics, Law and HIV/AIDS

STRATEGY 2017-2021

A NEW ERA IN HEALTH RIGHTS:

Fighting Marginalisation

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- Dissimination of evidence (see above) through direct engagement. - Strategising with others CSOs to make change (e.g. developing advocacy messages: testing policy briefs: etc) - Coordinating and alligning our efforts (a cotribution to movement building.) - Speaking with one voice: talking action together - Participating in key policy forum to ensure that important issues are raised; sharing policy briefs and alternative policies - Responding publicy to emerging issues from a health and human right perspective	- Human Right Monitoring - Commission research - Monitoring and Evaluation of the effects and impact resulting from all the areas of BONELA's work - Formulating policy briefs and alternative policies - Publishing reports as well as effective narratives, and packaging these in forms that are accessible and easy to use by various media	- Generating policy and practical solutions for health rights fulfillment, through the design, delivery and documentation of effective projects, services and interventions - Building the capacity of and/or partnering with, other CSOs to implement projects - Movement building; open up spaces for marginalised voice to speak for themselves and be heard - Building and supporting state capacity to address the health rights of vulnerable groups (advisory/technical assistance role) -Strategic Litigation

VALUES: Passion, Integrity, Commitment, Botho/Humannes

FORMATION AND IDENTITY

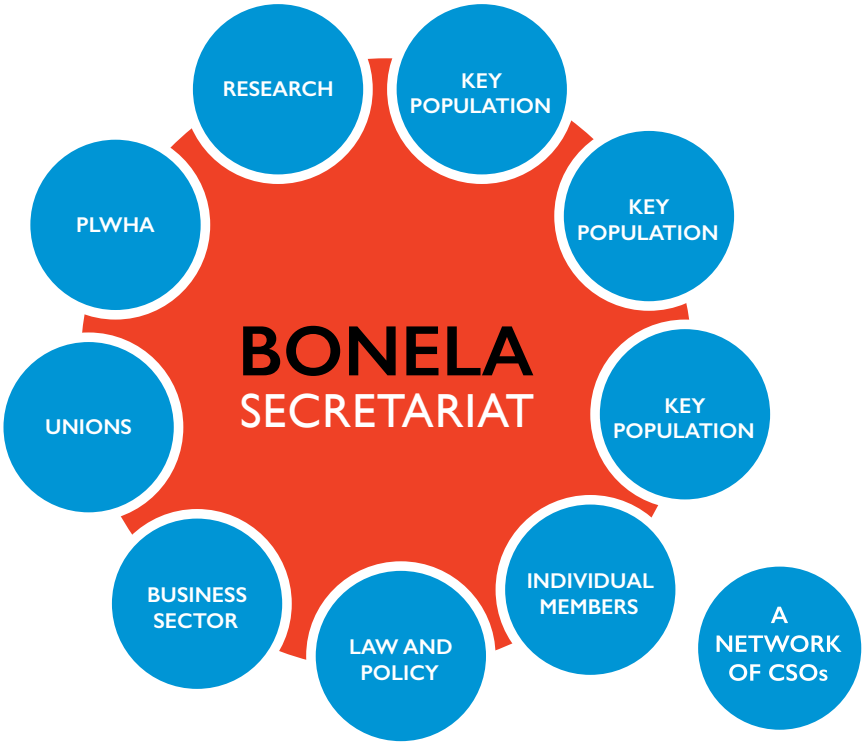
The Botswana Network on Ethics Law and HIV/AIDS (BONELA) was established and registered as a national network in 2002. Our purpose: to promote a human rights approach to HIV/AIDS and TB in Botswana through awareness raising, capacity building and advocacy.

Since inception, part of BONELA's unique contribution has been a focus on the human rights of vulnerable, marginalised and what are now (within HIV discourse) called Key populations.

STRUCTURE AND GOVERNANCE

We draw our network membership from individuals and organisations who share our overall values and vision. BONELA's 35 member organisations is structured into a number of sectors – see diagram below.

Our Board is elected from the membership at an Annual General Meeting (AGM) and plays a key role in framing and informing our strategic focus. We also engage and consult with our members more widely – specifically at the AGM, but also in an ongoing way as issues arise. Members resource BONELA's work (knowledge, skills, relationships) and ground us in a



constituency which gives legitimacy to our work.
Beyond this formal network, we also use networking as a key means of working with others towards common goals – i.e. we build operational networks of civil society organisations (CSOs) working on key issues and with key sectors of relevance to our strategy and goals.

All of this is supported by a small team of staff with competencies in a wide range of areas.

These include policy formulation, programme design and implementation, litigation, advocacy, and monitoring and evaluation – as well as considerable sector specific knowledge and experience around HIV, human rights, and Key Populations (KPs) in particular.

PAST ACHIEVEMENTS

Over the past 13 years a great deal has been achieved. Some particularly important and memorable contributions at national level include:

- Advocating for a rights-based approach to Sexual and Reproductive Health for women living with HIV – and specifically in relation to cervical cancer (2007-2010). Currently the turnaround time for cervical cancer results has reduced from 6 months to 6 weeks. In addition government has also introduced the "See and Treat" programme – an innovative, cost effective and more accessible cervical cancer screening system for women in hard to reach rural or clandestine communities.
- Hosting and supporting the development of Botswana's first LGBTI and Trans organisations (LEGABIBO & Rainbow identity) and the first Sex Worker organization (Sisonke) – all three organisations are now operating independently and effectively.
- In 2009, Influencing the National Strategic Framework on HIV/AIDS II (2010-2016) to incorporate strategies and interventions focused on key populations
- Reversing the implementation of the National Most at Risk Populations Strategy (MARPS) because of the punitive aspects (arbitrary arrest, detention and deportation of foreign gay men, lesbians and sex workers) it built into the HIV response. We continue to lobby through the National AIDS Council and the National AIDS Coordinating Agency for a revised framework that respects and upholds the rights of these Key Populations.
- With LEGABIBO, fighting and winning a long battle for the right to freedom of association for LGBTI people in Botswana (registration case) – appeal concluded in 2016.
- Since 2010 BONELA has fought for the rights of refugees (and more recently, foreign prisoners) to access anti-retroviral treatment. In 2015, BONELA won a case at the level of the Court of Appeal: government was ordered to provide free ARVs to foreign prisoners within the framework of the Botswana Prisons Act and Health Policy.

At regional and global levels, BONELA is a Linking Organization of the International HIV/AIDS Alliance (IHAA). As such, we participate in regional initiatives as well as contributing to and learning from a global network of organisations aimed at supporting an accountable, sustainable and rights-focused community response to HIV/AIDS. Further, BONELA's new strategy contributes to all four key pillars (response areas) of the Alliance's current strategy (2016-2020):

- Increasing access to quality HIV and health programmes
- Supporting community-based organisations to be connected and effective elements of health systems
- Advocating for HIV, health, gender and human rights
- Building a stronger Alliance partnership that is evidence-based and accountable to communities[1]

1 *BONELA hosted an African-wide meeting of Alliance partners in 2016 – a concrete contribution to this response area. We*

RATIONALE FOR OUR NEW STRATEGY 2

Change in an organisation's context needs to be met with some coherent response. This strategy aims to respond in particular to the present economic and civil society terrain in Botswana, as well as that of the global HIV/AIDS sector. Below we address each of these areas briefly.

CONTEXT

Social, Economic and Political

Botswana is lauded as an African success story: economic growth and prosperity, good governance, political stability and sensible macro-economic policy. These factors – and a significant endowment of natural resources – have enabled the country to transition from 'Least Developed Country' status at independence (1966) to 'Upper Middle Income' status 30 years later.

In spite of this, significant pockets of poverty and exclusion remain, especially in rural areas. Botswana's income inequality in one of the highest in the world with a Gini Coefficient of 54.2. The HIV/AIDS pandemic has exacerbated this situation: Botswana has the second highest adult HIV prevalence rate in the world, and a life expectancy of just 64.4 years. (UNDP, 2014) The economy is characterized by resource-intensive/extractive production, in particular, diamond mining. The unemployment rate is 17.8%.

Inequality and social exclusion are structural and cultural in nature. It is not enough to ameliorate the suffering of people on the fringes of society – whether they are there because of gender identity, sexual orientation, employment or economic status or some other factor. Addressing the presence of a significant group of excluded, marginalised and vulnerable people requires change in attitudes, policies and practices – it goes beyond just meeting their immediate needs in the short term.

These kinds of changes – which are attitudinal, discursive, behavioural and cultural in nature – do not happen overnight, and the work required to catalyse them is difficult to resource within the country. Privileged people and institutions have a stake in maintaining the status quo. Further, the potential for corporate financing is limited by the fact that big business is vulnerable to the removal of the mining and other rights granted them by government.

On top of this, the country's Upper Middle Income status has brought with it the withdrawal of many donors – and serious challenges in accessing core finance and funding for advocacy work in particular. Advocacy is a people-intensive activity – it is relational, so there are often no immediate products or easily measurable outcomes in the very short-term – and much project funding is very short term.

These realities call on us to find new partnerships and innovative ways of enabling the changes required for marginalised and vulnerable groups to realise their health and human rights in Botswana.

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also envisage growing our regional role in relation to developing civil society advocacy capacity in the coming years.

The HIV Sector: trends and changes

The past decade has seen the successful roll-out of anti-retroviral therapy by the state. While some challenges remain – access to certain commodities (e.g. condoms and lubricants); occasional shortages of drugs; ongoing stigma and discrimination in some quarters – the treatment situation has improved dramatically since the dark days of the 1990s and early 2000s.

With this shift at global level, as well as in Botswana, has come a strong emphasis on almost purely biomedical interventions. This is a consequence of the dominant thinking amongst many influential players about how best to achieve UNAIDS' 90-90-90 goals.[2] This in turn has resulted in a much reduced pool of finance for other kinds of HIV work – e.g. community level responses to HIV and interventions emphasising human rights and marginal voices. Part of BONELA's role in the coming period must be to continue to advocate for a combination approach to addressing HIV – biomedical, rights-based and community level interventions all contribute to addressing the epidemic. On balance, we do not believe that a purely biomedical approach will have sustainable impact.

However, in the light of the above – and the real progress that has been made with regard to HIV in Botswana – we recognise that the general population epidemic is no longer where we should place our main emphasis. Applying a human rights lens, it is clear that HIV should not be the only organising issue for BONELA's work. There are a wide range of Health Rights challenges and violations – some connected to HIV, some not – that BONELA is well placed to address.

We are therefore repositioning the organisation as a Health and Human Rights Network – rather than primarily focusing on HIV and Human Rights as in the past. Within this remit, a focus on Key Populations remains important, as does exerting influence to counter the trend towards simplistic, purely biomedical HIV interventions.

Key elements of the right to health

(a) Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs. (5)

2 *90% test; 90% treated; 90% viral suppression. Interestingly the latter 90% has yet to be achieved anywhere outside of highly controlled clinical trials. Perhaps because adherence to treatment is not primarily a biomedical issue but a human and social one. Testing and treatment also have social and psychological components which are too often ignored – even in resource-rich environments. Achieving these goals requires something more than a purely biomedical approach. Our strategy aims to address and create space for some of these other necessary ingredients.*

(b) Accessibility. Health facilities, goods and services (6) have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions: Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalised sections of the population, in law and in fact, without discrimination on any of the prohibited grounds

- Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalised groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities.
- Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.
- Information accessibility: accessibility includes the right to seek, receive and impart information and ideas (8) concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality.

(c) Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.

(d) Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

United Nations Economic and Social Council. The right to the highest attainable standard of health: 08/11/2000. E/C.12/2000/4. (General Comments)

Civil Society

Most Botswana civil society organisations (CSOs) have not adopted a strongly rights-based orientation. Much good work is taking place at the level of service delivery and care, but there is relatively little focus on systemic/policy/cultural change. This is a factor to consider when engaging with CSOs in general. The relatively 'thin' funding environment also brings with it the challenges of competition and fears of alienating state and government representatives. It will be important to navigate these waters consciously and with care, while attempting to build coalitions, effective partnerships and more rights-based capacity in-country.

On the positive side, BONELA's position as a rights and advocacy-focused organisation differentiates us from the majority of local and national CSOs: it is an important aspect of our brand and value proposition.

Further, BONELA's historical role as an incubator of organisations and nascent movements of marginalised and vulnerable people is a particular strength: in a sense BONELA has contributed very directly to the formation and development of a small cadre of civil society organisations that do carry the rights-based standard. As noted earlier, BONELA hosted several LBGTI and Sex Worker organisations, including LEGABIBO, Rainbow Identity and Sisonke. All of these organisations are now operating entirely or largely independently of BONELA though collegial and partnership relationships remain intact. This trajectory of supporting the development of nascent organisation as hosted projects, which develop into hosted organisations and then achieve independence from (and hopefully interdependence with) BONELA constitutes a replicable model that can be applied to other sectors and organisations moving forward – it a base to build on, deepen and develop.

POSITIONING BONELA IN THIS CONTEXT

The process of consultation, discussion and thinking that has gone into generating the strategy document you are reading now, has sought to take into account these realities and to draw on BONELA's core strengths to chart a course for the coming five years.

Some critical conclusions inform our new Strategy (2016-2020):

- HIV/AIDS remains a key and cross-cutting issue, but it is no longer the central issue. In light of this, BONELA is positioning itself as a **Health and Human Rights network.** Our overall vision focuses on contributing to universal access to health rights: **"Making health and human rights a reality in Botswana."**
- It follows that the **long term outcomes** we aim to achieve are:
  - Vulnerable and marginalized people (including Key Populations') know their health rights and assert them (with support where necessary).
  - CSOs, coalitions and emerging movements of vulnerable and marginalized people cooperate to support the protection, promotion and fulfilment of marginalized and vulnerable people's health rights.
  - The state and other duty bearers in the field of health adopt policies and practices that enable marginalized and vulnerable people to fulfil their rights.

  These outcomes will not be fully achieved in a five-year period. However, we aim to make significant progress towards them. See Section 4 for some of the milestones we aim to reach within the period.
- Our **core target groups** for the period are therefore:
  - organized civil society
  - the state and government
  - ordinary citizens (the public)
  - vulnerable/marginalized people

- The content of our work is informed by the realities facing 7 Core Strategic Populations. We have identified these groups based on a range of factors, including:
  - What groups are often excluded or denied their rights to health in Botswana?
  - Where can our competencies and skills be applied most effectively?
  - Where is the greatest need for justice and a rights-based response?
  - Where have we (and others) achieved success that we can build on?
  - What work is already financed and can be developed to deepen impact?

- The **Core Strategic Populations** we have selected are:
  - Lesbian, Gay, Bisexual, Transgendered and Intersex (LGBTI) people
  - Sex Workers (SW)
  - People Living with HIV (PLHIV)
  - Children
  - Prisoners
  - Mine workers
  - People with Disabilities (PWD)

- We engaged at length about the question of including women as a Core Strategic Population. Two conclusions were reached about this:
  - Women (or girls) are part of almost all of the above core strategic populations and we clearly recognize the need to ensure that their voices are strongly heard in the design and development of our projects and programmes. For example, lesbian, bisexual women and transwomen's issues should be addressed within our LGBTI programming. In the same way, women who are living with HIV, or disabilities would be addressed within those focal areas.
  - Beyond this, gender equity is a core human rights issue which goes beyond merely 'addressing the needs of women': it speaks to the inequitable power relations in society that produce the kinds of marginalization and vulnerability that we aim to counter. For this reason, BONELA aims to integrate a gendered lens into programme design and into our implementation and advocacy practice. Gender is a fundamentally cross-cutting issue and also opens the way for exploring the intersections between various Core Strategic Populations.
  - We argue that by focusing on health rights as a strategic point of leverage and by including the excluded (i.e. addressing the rights of marginalized and vulnerable sub-populations), we will contribute significantly to a shift in culture, practice and policy around health rights in Botswana, with positive spin-offs for building a stronger human rights culture in general.

See Section 4 for more information about the core strategic populations and our thinking and positioning in relation to each.

AUDIENCE AND PURPOSE OF THIS DOCUMENT

There is a lot of complexity in BONELA's work and in the Human Rights and Health fields in general. In this document we aim to map out only the essential issues – the WHAT and HOW of our work – as the basis for giving direction to more detailed programme and project planning and the development of related systems (e.g. monitoring and evaluation).
This document is not an operational plan – though we have developed an indicative work plan for the purposes of budgeting (see Annex 1).

BONELA's Strategy 2016-2020 sets out our approach and the goals we have chosen to hold ourselves to account for achieving. It maps the strategic terrain and our broad response to it: as such, it should inform all detailed project planning and decisions about resource mobilisation, allocation and BONELA's ongoing organisation development.

We hope this document will speak clearly to staff, members, partners, other stakeholders and a general readership about what the BONELA brand means and stands for in this 5-year planning period (2017-2021).

THEORIES OF CHANGE: How we catalyse change BONELA's core process 3

This section is based on our experience of working with and towards change over more than 10 years. While we have some specialised skills and experience in strategic litigation and advocacy, we recognise that contributing to social change requires a multipronged, multi-layered approach.

Below, we map out how BONELA can most effectively contribute to positive social change (development) in the Botswana health environment in the coming five years. We also address the implications of this approach for our practice and programming.

HOW DOES CHANGE IN HUMAN SYSTEMS HAPPEN?

Societies, states and governments, other organisations, families and individuals are all examples of human systems. For conscious change to happen, a basic sequence of steps usually needs to be supported:

1 **Raising awareness:** The system (and people in it) needs to become more deeply aware of the current reality. In other words, people become more informed about the existence and issues facing a part of their community – whether LGBTI people or Sex Workers or Disabled People or another group. They have more information, knowledge and understanding (cognitive level) of the issue or group, which in turn means that it is less unknown, alien and other – and their minds are opened for deeper engagement.

2 **Connecting to feeling/affect and empathy:** Information and knowledge is often not enough to provoke change in attitudes, deeply help beliefs and/or behaviour. People have to feel some emotional connection to the information: this is where the will to change comes from. Put another way, they have to care enough about the issue and the people involved to bother. This is about empathy – opening people's hearts, beginning to see their own part/ownership/role in maintaining the current situation, and hopefully access the will to change.

   There is no better way to achieve this than by supporting people who experience injustice and marginalisation to speak their truth. We support this by engaging and working with[3] organisations from and of the affected communities (core strategic populations): no one else is better able to raise awareness about their lived experiences while connecting to feeing/affect and empathy.

   Working effectively at stages 1 and 2 and using multiple channels to do so (e.g. media, direct contact, dialogue, narratives, etc.) produces champions of the issue that you are trying to address – these people become an important focus as one moves into later stages of the work.

3 **Offering solutions or finding them together:** Without some kind of solution or relatively clear and implementable response (i.e. one that is not so personally or economically costly that it is rejected outright), issues are simply swept under the carpet – if there's no solution, awareness and empathy is merely exhausting and meets with resistance.

3 *This support takes the form of traditional capacity development and strengthening work (i.e. capacity assessments, implementing capacity development plans, regranting, etc.) with partner organisations as well as connecting and accompanying them into spaces where their voices and stories can be more effectively heard.*

It is important to offer a concrete way forward so that the energy mobilised in step 2 has somewhere to go. (Depending on the situation, one can offer options or a single solution; but best of all is finding a solution together with those involved so that they own it and are committed to it.)

As a change agent or catalyst we aim to build real relationships with members of the system: contact, connection and developing affinity and trust are important ingredients in catalysing and sustaining change.

4 **Making a choice:** The actual choice is often not in our control. If we stand outside or on the edge of the system (e.g. parliament, a state department, or another organisation) or if the system is very large (e.g. the general population or even that of a district) then a great deal of vigorous work at the previous three stages is often needed before getting to the point of Choice. It is not necessary for every system member to agree with a choice, but key people (champions) or a critical mass should accept the need for change and want to change.

Where there is significant resistance/stuckness, and a choice is not emerging from this process of engagement, more challenging interventions may be needed – e.g. a shift from education and awareness raising to campaigning or strategic litigation.

5 **Ensuring capacity exists to implement the choice:** A new policy without any capacity to implement or readiness to monitor progress will probably not lead to any real and lasting change. Offering support (technical assistance, accompaniment, advice, joint implementation, etc.) is an important contributor to success at this stage. This kind of support continues through...

6 **Monitoring and supporting implementation**

7 **The change in state of the system and of the issue that we were aiming to address should become visible** – i.e. it becomes possible to say, "Change has happened!"

This is our working theory of how change happens in groups of people, societies and organisations. It is supported by our experience and it accommodates a range of different levels of intervention – from very light and facilitative to more radical/activist efforts or challenges through the courts. While it is represented as linear, in reality, as circumstances change and new issues arise, it is often necessary to go back several steps or return to the beginning of the process. By the same token, sometimes change to one key policy or practice can unleash a ripple of changes through the social system: finding these strategic points and the key outcomes that would enable them has been a critical part of the strategic thinking process that produced this document.

See overleaf for a diagrammatic representation of this process.

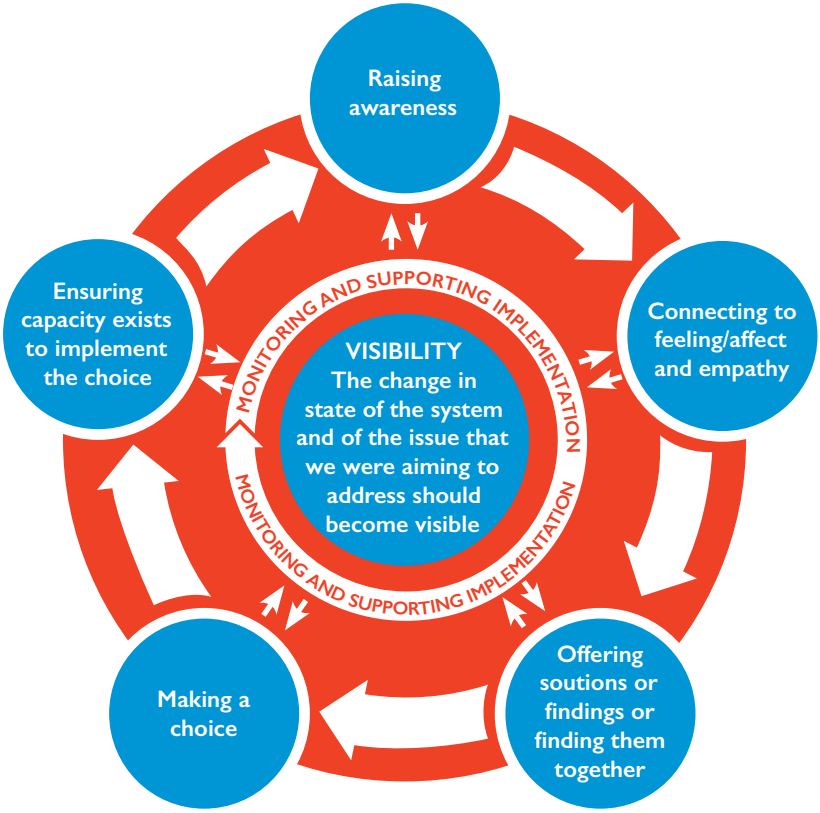

Figure 2. Structure of the BONELA Network.

In the coming period, we aim to apply the above understanding more consciously to the design of our work: every activity and point of contact between BONELA and other systems (especially those affecting people's health rights) should aim to further some aspect of this process.

HOW DOES BONELA CONTRIBUTE TO SOCIAL CHANGE?

BONELA works at a number of different levels – directly with citizens, with civil society organisations, with service providers, duty bearers and policy makers (e.g. the courts, state departments, politicians and technical experts, etc.). At each of these levels, different elements of our work become salient at different times. Below we draw the links between the functional areas of BONELA's work and our theory about how social change may be supported.

	AREA OF WORK	STEPS IN THE CHANGE PROCESS
1	Generating and packaging evidence Activities include: - Human Rights Monitoring - Commissioning research - Monitoring and Evaluation of the effects and impact resulting from all areas of BONELA's work - Formulating policy briefs and alternative policies - Publishing reports as well as affective narratives, and packaging these in forms that are accessible and easy to use by various media, other CSOs, policy makers, and the general public.	This area of work supports: 1. Awareness 2. Affect/emotional connection/empathy 3. Identifying solutions 4. Choice
2	Networking and dialogue With members, partner organisations, citizens (community level) and government. Activities include: - Dissemination of evidence (see above) through direct engagement - Strategizing with other CSOs to make change (e.g. developing advocacy messages; testing policy briefs; etc.) - Coordinating and aligning our efforts (a contribution to movement building) - Speaking with one voice; taking action together - Participating in key policy forums to ensure that important issues are tabled; sharing policy briefs and alternative policies - Responding publicly to emerging issues from a health and human rights perspective	1. Awareness 2. Affect/emotional Connection/empathy 3. Identifying solutions 4. Choice 6&7. Monitoring implementation & change
3	Projects As a not-for-profit organisation, projects are a key way of organising and financing our work. A project has a beginning, middle and end, and is usually supported by one or more donor. Activities include: - Generating policy and practical solutions for health rights fulfilment, through the design, delivery and documentation of effective projects, services and interventions which address the challenges of marginalised and vulnerable groups (and ultimately all citizens)	

3	- Building the capacity of, and/or partnering with, other CSOs to implement these projects – by working together, sub-granting, coaching, training and offering technical assistance - Movement building; open up spaces for marginalised voices to speak for themselves and be heard - Building and supporting state capacity to address the health rights of vulnerable groups (advisory/technical assistance role) - Advocating for change through all of the means above, and via campaigns and strategic litigation	3. Identifying/generating solutions 4. Choice 5. Capacity development for implementation 6&7. Monitoring and supporting implementation &w change
Note: Some aspects of Generating and Packaging Evidence and Networking and Dialogue are important parts of most Projects (e.g. research; coordinating the efforts of several partners; etc.). We nevertheless draw a functional distinction between these three areas because each requires different core skills and somewhat different management approaches. Further, there is a need to invest energy and resources in strengthening Areas 1 and 2 in order to remain effective in Area 3.		

AREAS FOR DEVELOPMENT AND ALIGNMENT

It is worth noting at this stage that the third area of work – i.e. Projects – is currently most well-developed in BONELA. This is probably inevitable: sustaining the organisation at a time when core financing is extremely rare requires that we engage in project implementation, as does our mandate to protect, promote and fulfil the rights of vulnerable and marginalised people.

However, it is also clear that being really effective and making sustainable change requires a stronger focus on Generating and Packaging Evidence and Networking and Dialogue. These two areas of work directly inform and enable our implementation, service delivery and advocacy work.

A priority for the coming period is to ensure these are better resourced in both human and financial terms. It also requires that more attention is paid to developing our organisation and strengthening its resilience. The subsection below explores this briefly.

Developing and strengthening the organisation: maintaining the vehicle that carries the work

In order to be effective in the areas above, it is necessary to maintain and strengthen ourselves as an organisation so that we remain able to respond vigorously, creatively and effectively to our environment.

Some activities in support of this enabling work include:

- Continuing to build a conscious, effective and developmental organisational culture
- Aligning organisational capacity and systems to our new strategy:

- Strengthen the programmes team (employ a network manager; increase general programme management and implementation capacity; strengthen research and M&E capacity).
- Build an M&E system aligned to the new strategy
- Resource mobilisation will become a much stronger focus of the Executive Director; focus on seeking good quality finance (core/institutional; reasonable overheads, etc.).
- Enhance independence and sustainability by encouraging key staff to spend a portion of their time working on consulting and product development (generating surplus) – build a regional (African) practice and grow our profile as leaders in civil society influencing and advocacy work.

In general, we are moving from an activist orientation to positioning ourselves as a strategic advocate, a change agent and a technical advisor, focusing on law reform, policy and programming for vulnerable and marginalised populations. This more strategy-oriented stance is necessary for us to achieve our goals.

BONELA'S CORE PROCESS

The diagram below maps out the essence of BONELA's core process/organisational logic and pulls together the key elements discussed in this section.

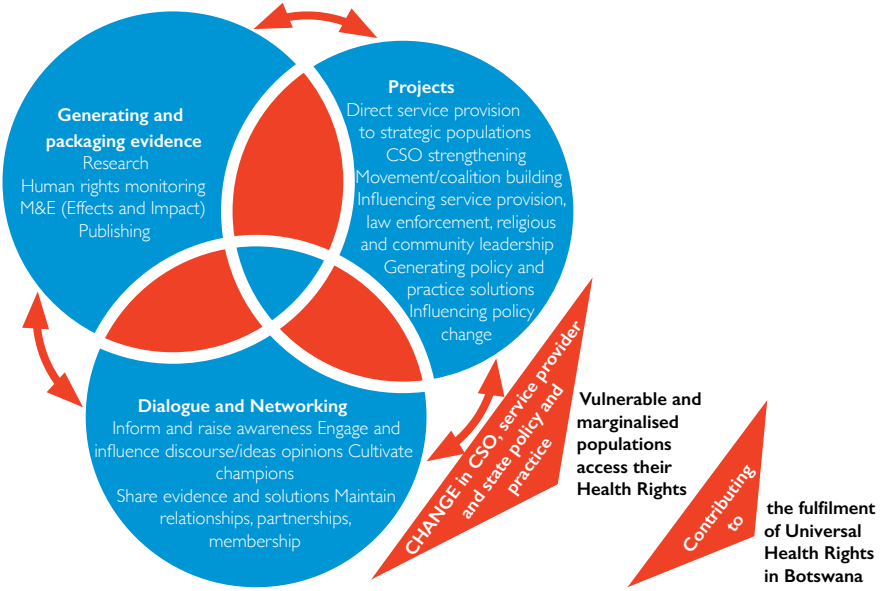

Figure 4. BONELA's organisational logic/core process: How we contribute to the realisation of health rights for vulnerable and marginalised groups (and for all in Botswana).

Strategy 2016-2020: Strategic goals, BONELA's intervention, key milestones 4

The previous section explains how we work. This section looks at what the work will focus on – i.e. the content, issues and people involved – and on what we aim to achieve in the coming five year period.

As already noted, BONELA aims to contribute to the fulfilment of health rights for all in Botswana. We believe that addressing the rights of vulnerable, marginalised and excluded people is the right place to start: recognising them as important – as fully human – will support a shift towards the kind of culture of service delivery, human rights and botho that we seek to build in Botswana.

In light of this, our new strategy is organised around the realities, issues and challenges facing 7 strategic populations. In the table overleaf we unpack:

- why each of these populations is significant,
- what overall change we want to contribute towards (strategic goals),
- the focus and nature of BONELA's work in relation to them, and
- map out the short (1 year), medium (2-3 years) and longer term (5 years) outcomes we will use to measure our effectiveness and steer this strategy towards success.

We recognise the reality of intersectionality – of overlap between these strategic populations. We will address this at project level by working consciously with these factors and explore them in our evidence generation, networking and dialogue work.

At this point, it is worth stating some high level indicators which will be further refined as measures our overall impact as this strategy is operationalised:

1. Vulnerable and marginalised groups (a) know their health rights and (b) assert them (i) individually and/or (ii) through their organisations/movements.
2. Friendly, high quality health services are (a) accessible to vulnerable and marginalised people and (b) utilised by them. (These include services and commodities that promote and protect physical and mental health, as well as addressing its absence.)
3. Social stigma against vulnerable and marginalised groups is reduced; they are more accepted/valued in the larger community/society.
4. Policies enabling all of the above are (a) in place and (b) being implemented to a high standard of quality.

STRATEGIC POPULATION	WHY	STRATEGIC GOALS
People Living with HIV (PLHIV)	A key population (HIV). There are well-established civil society organisations though the community-level response is under- resourced. There is a need to continue to advocate for a combination approach to HIV, communities, human beings and their health rights – the current dominant discourse (90-90-90) tends to privilege biomedical aspects only;	• Funding for the sector is sustained and increased • Principles of Positive Health, Dignity and Prevention integrated into civil society and government policy and practice • Sustaining access to quality treatment and adherence.
Lesbian, Gay, Bisexual, Transgender and intersex people (LGBTI)	A key population (HIV). Same sex relations remain criminalised and stigma and discrimination are still a factor limiting LGBTI people's access to their full human and health rights (although the situation has improved over the past decade). BONELA has been a pioneer in this area in Botswana – in partnership with several LGBTI organisations. There is a fairly strong and developing LGBTI sector and several legal and policy level successes have been achieved (e.g. LEGABIBO's right to register appeal). At the same time, many smaller organisation remain unregistered. There remains an ongoing need for awareness raising, service delivery and attitudinal change – especially outside the major population centres – as well as policy change at national level.	• The LGBTI sector is strengthened and enabled to: - advocate effectively for their constituency's health and human rights (in partnership with BONELA); - service their constituency effectively (psychosocial, legal, health and other services).

NATURE OF BONELA'S INTERVENTION	SHORT TERM OUTCOMES	MED-TERM OUTCOMES	LONGER TERM OUTCOMES
Technical support (incl. advocacy/ strategic litigation support where appropriate) to, and partnership with, PLHIV organisations and movements. Where possible, joint programming or sub-granting to the sector. Participating in International HIV/AIDS Alliance-level advocacy, targeting state and international donors – pushing for the importance of a combination approach to HIV programming. Increasing access to essential medicines	Principles of PHDP popularised among government, civil society, the public and PLWHIV Well-coordinated community response Increased transparency around drug availability.	Joint advocacy for the integration of PHDP into health policies and practices Easier access to second-line ART and testing where required	Sustained an effective response to HIV at community, service delivery and policy levels Sustained and increased funding for the sector
Solidarity with and technical support (incl. advocacy/ strategic litigation support where appropriate) to, and partnership with LGBTI organisations and movements. Where possible, joint programming or regranting to the sector.	Sustained and increased funding for the sector Increased capacity of LGBTI organisations to advocate effectively	Increased access to services for the LGBTI constituency	Increased influence towards policy and law reform for LGBTI Milestones towards an enabling environment for LGBTI achieved

STRATEGIC POPULATION	WHY	STRATEGIC GOALS
Sex Workers (male and female)	A key population (HIV). Similar to the LGBTI experience, BONELA has supported the development of a Sex Workers' organisation in Botswana (Sisonke). Issues of stigma and access to services remain a challenge, as does criminalisation and all it implies.	• The Sex Worker sector is strengthened and enabled to: • advocate effectively for their constituency's health and human rights (in partnership with BONELA); • service their constituency effectively (psychosocial, legal, health and other services).
Children (0-18)	While there are many organisations working with children's issues in Botswana few (if any) work from a Human Rights perspective. We see many rights violations in this relation to this strategic population.	• Children's Act guidelines produced and implemented by police, social workers and courts • Key service providers (in particular, state health and education facilities) fulfil children's human and health rights (child-friendly services) • Societal knowledge and attitudes towards children's rights are improved.

NATURE OF BONELA'S INTERVENTION	SHORT TERM OUTCOMES	MED-TERM OUTCOMES	LONGER TERM OUTCOMES
Technical support (incl. advocacy/ strategic litigation support where appropriate) to, and partnership with, SW organisations and movements (including support for registration). Where possible, joint programming or regranting to the sector.	Sustained and increased funding for the sector Increased capacity of Sex Worker led organisations to advocate effectively	Increased access to services for Sex Workers	Increased influence towards policy and law reform for Sex Workers Milestones towards an enabling environment for Sex Workers achieved
Networking and dialogue with the sector and relevant state departments. Joint advocacy for effective policy implementation in relation to Children's health rights.	Sustained and increased funding for the sector Increased awareness of children's rights among children service providers and the public	Advocacy to ensure Increased capacity to implement the Children's Act guidelines by service providers	Improved societal knowledge and attitudes towards children's rights Increased monitoring of the implementation of the Children's Act and guidelines

STRATEGIC POPULATION	WHY	STRATEGIC GOALS
Prisoners	A key population (HIV). TB and HIV are both critical factors affecting prisoners, as well as a host of psychosocial and reintegration challenges. BONELA has, through the courts, challenged for foreign prisoners' rights to access antiretroviral medication. We aim to build on this success. In addition, there are emerging organisations in this sector (e.g. BIRRO) which present opportunities for partnership and strengthening the sector.	• The Prisons Department, courts, police and the Ministry of Health address key health rights issues facing prisoners, including: - Access to HIV and TB prevention and treatment information and services (including infrastructural changes); - Access to legal aid to address rights violations. - Access to condoms and HIV education in prisons - Research on prevalence in prison
Miners	The health rights of miners have been long ignored in Botswana. TB is a particularly pernicious issue, often connected to silicosis. Issues around health, safety and compensation abound. This is an emerging area of work for BONELA.	• The health rights of miners are defended where they have been violated (going forward and retrospectively). • State policy and mining company practice protect and promote the health of mineworkers.

NATURE OF BONELA'S INTERVENTION	SHORT TERM OUTCOMES	MED-TERM OUTCOMES	LONGER TERM OUTCOMES
Networking and dialogue with the emerging sector and relevant state departments. Research to establish the reality of HIV transmission, etc. in prisons. Capacity development and technical support (incl. advocacy/ strategic litigation support where appropriate) to ex- prisoner organisations and movements. Where possible, joint programming or regranting to the sector.	Sustained and increased funding for the sector Increased access to legal aid	Increased access to legal aid Technical capacity policy and legal reform (Ministry of Health, Prisons Department, BIRRO)	Increased access to TB/HIV services for prisoners Milestones towards enabling policy and law environment for Prisoners achieved
Engage in research as the basis for developing an advocacy strategy. Networking and dialogue with the unions, employers and relevant state departments.	Sustained and increased funding for the sector Increased access to legal aid	Increased access to legal aid Technical capacity policy and legal reform built	Milestones towards enabling policy and law environment for miners achieved

STRATEGIC POPULATION	WHY	STRATEGIC GOALS
People With Disabilities (PWD)	As in the case of Children, there are several organisations working in this sector, but there remains a need to balance the focus on care with a focus on rights. There is no coherent government policy pertaining to people with disabilities. Recent developments in the sector include the formation of a secretariat bringing together several organisations focused on the needs of people with disabilities. BONELA aims to collaborate with and support this process as well as getting people with Disabilities health rights on the agenda.	- Coherent, rights-based policy on People With Disabilities is in place at national level and being implemented. - A strengthened sector monitors and supports the implementation of this policy.

NATURE OF BONELA'S INTERVENTION	SHORT TERM OUTCOMES	MED-TERM OUTCOMES	LONGER TERM OUTCOMES
Networking and dialogue with the emerging sector-level organisation and relevant state departments. Participatory policy development – to contribute to fill the policy gaps. Capacity development and technical support (incl. advocacy/ strategic litigation support where appropriate).	Sustained and increased funding for the sector Increased capacity of PWD organisations to advocate effectively Increased knowledge on PWD issues Increased access to legal AID	Technical capacity for policy and legal reform built Increased access to legal aid	Advocating for policy and law reform Technical capacity for policy and legal reform

Timelines for Implementation 5

PERIOD	FOCUS	RESPONSIBLE
Year 1 (2017)	**Adapt overall resource mobilisation strategy and organisational structure/systems (incl. M&E system) to new strategic plan.**	SMT
	Augment BONELA's capacity in the fields of: • Health Systems Strengthening • M&E and research (generating and packaging evidence) • Networking and dialogue • Partner capacity development	SMT
	Mobilise resources for Years 2-5 where needed.	Executive Director (ED) with SMT
	Develop costed work plan for Year 1 of the strategy (see Annex 1 to this document for a draft version).	Finance Manager Prog Manager
	Implement work plan through Generating and Packaging Evidence, Networking and Dialogue, and Projects.	All staff, with partners
	Develop products for income generation: • National level: Develop and launch Legal Insurance product • Regional level: - Develop Advocacy training and consulting products - Pilot with Alliance Centre/KP Connect	Finance Manager Prog Manager
	Quarterly strategy review meetings	Prog Manager
Year 2 (2018)	**Roll-out income generation products to increase financial reserves and discretionary funds.**	Prog Manager
	Ongoing resource mobilisation	ED
	Work planning and implementation	All

PERIOD	FOCUS	RESPONSIBLE
Year 3 (2019)	Mid-term: review progress towards Strategic Goals and milestones/outcomes; review the core process	SMT and Evaluator
	Ongoing resource mobilisation	ED
	Work planning and implementation	All
Year 4 (2020)	Ongoing resource mobilisation	ED
	Work planning and implementation	All
Year 5 (2021)	Ongoing resource mobilisation	ED
	Work planning and implementation	All
	Commission Evaluation: - Review current strategy; develop Strategy 2020-2024.	SMT

Risk Management

6

RISKS/THREATS	MITIGATION MEASURES
BONELA has a "Love/ Hate" relationship with Government. In certain instances we are fully included in policy processes; in others, we are completely excluded from government processes. The state could refuse to engage with us or adopt an actively hostile stance. BONELA's generally high profile and regional and international connections make this an unlikely outcome, but nevertheless, this is a set of relationships that needs to be consciously managed.	Develop a policy statement around BONELA's government engagement and advocacy work and communicate it clearly (and regularly) to the state and other stakeholders. (See for example the clarification note in Annex 3 to this document; this could form the basis for such a policy.)
Diminishing core finance; and an increasing trend of reduced space to build institutional costs into project proposals. At end-2016 OSISA will no longer provide core funding (changing business model). This leaves a significant gap in BONELAs unrestricted funding. Some unrestricted funding is vital for the implementation of this strategy – it cannot be achieved with a purely project-driven approach because the project format does not allow sufficient time and financial resources for the critical networking, advocacy and evidence generation work. At the same time we need to improve our proposals and plans – i.e. build in costs more effectively wherever possible.	Implement BONELA's 2015 Resource Mobilization strategy: • Overheads policy • Proposals pipeline system and donor database • Proactive grant-seeking (project and core costs) • Finalize feasibility studies of income generation activities (consulting & legal insurance) and implement the one most likely to pay dividends in the short to medium term (replacing the OSISA loss and building reserves is a priority).

RISKS/THREATS	MITIGATION MEASURES
Retaining and acquiring the skilled personnel needed for effectiveness and efficiency. This is directly related to the financing situation.	Seek creative means of retaining and adding capacity (in particular in research, documentation and network/relationship management). Some options could include: • Overseas volunteers • Non-financial benefits (flexible working hours/spaces) • Part-time/contractual positions • Building a resource pool of trusted consultants willing to work with BONELA at reasonable rates (based on shared values and interest) • Draw more consciously on the skill sets of members, Board and partner organisations to augment BONELA's capacity (e.g. the Research sector of the Network).
• Demand-driven vs. Maintaining a Strategic orientation • Principled vs. Tactical choices There is a danger of being distracted from this strategy and the values that underpin it due to survival pressures (finding funds to maintain the organization) and demands from stakeholders for work that we are not prioritizing.	• More energy at leadership level to be devoted to balancing the organization's traditionally activist and highly responsive style against a more intentional stance; stick to the strategy and our principles unless there is excellent reason to deviate from it. • It is critical that BONELA not slip into a survival orientation: our project choices need to be informed by principles and strategy, not merely by the need for income. This does not mean that no 'tactical' work should be done, but that we must watch the balance between principled and tactical/income generating work and maintain a focus on the strategic direction contained in this document.

Conclusion 7

We would value your feedback and engagement with us around this strategy. Please feel free to contact us using the details on the cover page.

We are excited about this next step in our work and about the contribution we can make to Botswana and to our many colleagues and partners. We hope you will join us and support us as we embark on this next phase of our journey.

Annex 1: BONELA's approach to advocacy

All of our work is about supporting change and development – in knowledge, understanding, thinking, attitudes, practices and policies – at the level of the public, CSOs, the state and the government. So all our work speaks to some degree to advocacy. For example,

- regranting to a Sex Worker organisation to enable them to deliver SRHR training and services to their constituency: this is about enabling people to become aware of their rights and immediately access some needed health care services
- participating in a high level meeting on policy as it affects the LGBTI community and offering an alternative, rights-based perspective of the issues: this can contribute to shifting the policy discourse and, over time, influence policy makers' attitudes and choices, leading to better policy design.

However, the state, government and other powerful actors have often seen BONELA as applying a more narrow definition of advocacy: campaigns, strategic use of media (responding forcefully to issues; engaging in public debates; etc.) and strategic litigation. We believe that these are all legitimate activities. Like all advocacy work, they are about increasing pressure for positive change.

Interventions such as (wisely applied) strategic litigation places structural pressure on the state to comply with court rulings. Similarly, campaigns in which citizens and CSOs petition government, mobilise support via social and traditional media, engage in direct lobbying, or take to the streets, also have their place.

However, while these modes of engagement can be effective and are part of a democratic political and legal system, we also recognise that they are basically coercive and sometimes give rise to unintended consequences (damaged or antagonist relationships; backlash; etc.). They should therefore be used strategically and sparingly – and only where other alternatives have been exhausted and the risks and costs carefully assessed, or where the issue at stake is extremely urgent. The avenues of dialogue, targeted research to gather convincing evidence, and support and engagement should always precede more aggressive action. And in principle BONELA always remains open to dialogue and engagement with all stakeholders (the only exception being when matters are sub judice).

In summary, human beings' right to health is at the heart of all our work and the passion that drives BONELA – it is something we cannot compromise on. Where necessary more structural and activist modes of motivating for change remain a part of our repertoire and of our history. But they are not the core of our work or our approach: engagement, evidence, solutions and support, are.

Wherever possible, we seek collaborative and complementary relationships with the state and all other keys actors in, and impinging on, the health system.

Annex 2: What is already being implemented? (2016)

Name of the Project	Description	Primary targets
Children's Rights (CR)	CR is aimed at making human rights a reality in Botswana through increasing Botswana government's responsiveness to child rights violations, increasing awareness and knowledge on children's rights among Parliamentarians, Civil Society Organisations, and traditional leaders as well as improving collaboration and coordination of child service civil society organisations through a Child Rights Network	Children
Proudly Combined (PC)	A project implemented with other regional organisations as a partnership project aimed at addressing structural barriers that hinder LGBTI and MSM communities to access health, legal and social services in Botswana.	MSM Sex Workers LGBTI Prisoners
KP Connect	KP Connect – Improved technical capacity among civil society organisations to promote KP access to HIV, health and rights services	LGBTI Sex Workers
Alliance Strategic Grant 2016	Organisational Development (Change Process), Strengthening Governance and Program Implementation	BONELA
Bridging the Gaps (BtG)	BtG is aimed at scaling up access to HIV prevention, care and support services for the LGBTI population using a rights-based approach by mainstreaming LGBTI health needs in public and private care service provision.	LGBTI, health care workers
Addressing Stigma and Discrimination to increase access to services for marginalised communities	Aimed at addressing stigma and discrimination to facilitate access to HIV, Health and Social services for marginalised and Most at Risk Populations in Botswana	People living with HIV, Peo ple with disability (PWD) Young people, Women, LGBTI Sex Workers

Secondary targets	Collaborative partners (and/or sub-grantees)	Donor	Start	End
Service providers Policy makers General public	Ministry of Local Government and Rural Development (Department of Social Protection-DSP) Ministry of Education and Skills Development Civil society organisation working on Children 's issues	Save the Children International	2013	31/12/16
Policy makers, Health care workers, Prison Officials, Traditional and Religious leaders,	Ministry of Labour and Home Affairs Ministry of Health National and Regional KP CSOs	AidsFonds	2014	31/12/16
Health Care Workers Policy makers KP organisations	LEGABIBO SISONKE BOFWA Ministry of Health	International HIV/AIDS Alliance	1/4/15	31/12/17
BONELA Network	Positive Vibes	International HIV/AIDS Alliance	1/1/16	31/12/16
Health care workers, policy makers	BOFWA, Ministry of Health, National AIDS Council, Men for Health and Gender Justice, Pilot Mathambo Centre, Parliament	COC	2013	31/12/16
Service Providers Lawyers Judges, Policy makers, Media, social Teachers,	Ministry of Health, Ministry of Labour and Home Affairs Ministry of Local Government and Rural Development, Media Houses CSOs.	Finnish Evangelical Lutheran Mission (FELM)	1/1/2014	31/12/2017

Name of the Project	Description	Primary targets
The Linkages Program	Implementation of HIV prevention, care, and treatment services for the KPs (FSW and MSM) men to prevent and mitigate HIV and AIDS	FWS MSM
Promotion and Protection of the rights of marginalised and rural communities in Botswana	The objective of project is the Provision of Nation-wide Human Rights Civic Education to increase and deepen civil society organisations' engagement in Human Rights and democracy in Botswana and to channel that into concrete action targeting 5 designated rural communities benefit from an enabling environment where the rights of all its people including populations most at risk (LGBTI, Women and Children) are protected and respected without prejudice and where services and justice are accessible to all'.	Children Women LGBTI Youth
SOSU II	This project is aimed at addressing the needs of sex workers, creating awareness on the prevention of minors exploited in trafficking and sex work, developing a rights and responsibility charter for minors exploited in to sex work.	Sex workers, Parents and Guardian Cohorts
Stepping Stones	Research on minor sex workers	Minor Sex Workers
Global Fund	Implementation of HIV prevention, care, and treatment services for MSM to prevent and mitigate HIV and AIDS	MSM
Global Fund	Removing Legal Barriers to increase access to HIV/TB services	PLWHIV

Secondary targets	Collaborative partners (and/or sub-grantees)	Donor	Start	End
Prioritised MSM and FSW CSOs	Ministry of Health District Health management Teams	FHI 360	1/3/2016	31/10/16
Service providers Judiciary Civil and Political Leadership Policy Makers	Government of Botswana through District level structures	EU	1/9/2015	31/9/2017
Adult sex workers, health care workers, social workers, police, court judges, policy makers,	Ministry of Justice, Defence and Security, Sisonke, Ministry of Local Government and Rural Development, Ministry of Education and Skills Development	AIDS Fonds	1/12/2014	2016
Adult sex workers, health care workers, social workers, police, court judges, policy makers	Ministry of Justice, Defence and Security, Sisonke, Ministry of Local Government and Rural Development, Ministry of Education and Skills Development	AIDS Fonds	1/1/2015	2016
Health Care Workers CSOs	Ministry of Health ACHAP CSOs	ACHAP through GF	1/5/2016	2018
General Public	Ministry of Health ACHAP CSOs	ACHAP through GF	1/5/2016	2018

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